AN INTEGRATED STATE MENTAL HEALTH PROGRAM

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-By-
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I approach this task with humility. My original intention was to present a very light-hearted 15 or 20 minutes on hospital-community relationships and let it go at that. In the absence of Dr. Dörken I had two choices--to present my material and then to present his, or to write a new paper which would with reasonable fairness be considered as a concerted policy statement on the part of all of us in the central office. While I cannot pretend that Dr. Dörken or any other member of my staff would subscribe to my comments 100%, I think it is fair to say that we are in substantial accord. In any event these are my views on what a comprehensive mental health program could and should be doing.

First let me identify myself as to coloring or the kind of animal I am. I think it is fair to state that I am basically something of a radical--though in conservative garb.

Second, I should describe something of my present position, so that you will have a clearer idea of my vantage point and the way I see things. I have responsibility for a crippled children's and a tuberculosis program--I mention these for the sake of completeness without meaning to discuss them further. More relevantly I have under my direction a comprehensive mental health program. This includes direction of the hospitals for the mentally ill; institutions (medical and educational) for the mentally retarded and a large community program for the retarded manifested by large numbers of people on the waiting list for admission to institutions; a program in mental health training and one in mental health research; somewhat more indirectly according to our laws and procedures, a community mental health program, under the immediate direction of Dr. Dörken. I operate under the direction of the Commissioner of Public Welfare on the basis of delegated authority and I in turn as a matter of sheer survival delegate

authority quite freely.

I mention this to make it clear at the outset that the breadth of my program responsibilities forbid my favoring one program at the expense of another and in fact force me to take the position of integrationist or federalist.

Third--and this will explain my comment about conservatism--I am a student of rumbles. As a leader of a program which is dependent on public good will I cannot afford to be otherwise. Through my excellent staff consulting the institutions, and directly from the superintendents, I hear rumbles from the institutions. From Mrs. Poor and Dr. Dörken I hear rumbles from the Community Mental Health Centers. Through informal channels I hear rumbles from the lay mental health leaders and lay leaders with an interest in the retarded. Through another channel I hear rumbles from the county welfare departments--this channel is a roundabout one that comes through the county welfare departments to their directors, to our field staff, to the field services director in our office, to Mr. Hursh and then back to myself. Another important channel is that of legislators who in one way or another make direct requests, complaints and occasionally commendations to Mr. Hursh. One gets possibly oversensitized in such a position and overly affected by complainers and the lunatic fringe. Nevertheless, whatever other advantages such a position may have, it has great satisfaction as a listening post. I will return to this subject later.

Now a parable. Once there was a nation at war. It had an army, a navy, an airforce, a coast guard, and a mobile striking force. Each of these major services in turn had a number of subdivisions: the army had infantry, artillery, supply corps, intelligence, etc.; the navy and airforce likewise had many subdivisions. Each night in bars sailors, soldiers, airmen and marines quarreled and fought as to which service was the most important. Each evening over cocktails retired officers in army-navy clubs disputed over which branch was the most important. Each day in the central headquarters of the war department generals, admirals and air marshals debated and secretly and openly tried to convince government leaders that their branch was the most important.

One day while they were all arguing the enemy dropped a cobalt bomb and the war was over.

The point is obvious. But for us the end will not be abrupt but subtle and cruel, or in the words of the poet, "Not with a bang but a whimper."

We do in fact encounter partisan views. Dr. Balester has spoken of equally defensible extremes concerning community mental health--that it will save society on the one hand, or that it is a lot of baloney on the other. Debate rages about public mental hospital services. Is the state hospital dead? If so, why doesn't someone bury it? Do they know they are dead? How big should a hospital be? Etc., etc. Let us face a few facts of life. The hospitals are here, they employ people (large numbers of them) and support communities; they comprise deep and complex networks of power operations and investment cathexes, and they are--if possibly ugly--familiar. My prediction is that we will have to live with them for many decades.

As things are now I think we see a rather simple pattern: easy problems are treated at the Mental Health Centers and difficult problems at the hospitals. I prefer instead Dr. Balester's concept: let simple problems treat themselves or be treated in situ, let difficult problems be treated by the clinic professionals. Very good. There still remain the most difficult category--and even psychiatric units in community hospitals <u>as they are now</u> very probably cannot manage these problems.

What are they?

1. Most seriously disrupted schizophrenics
2. Serious suicidal risks
3. Medically critical alcoholics

   (one might say--a good community program with a community hospital psychiatric service can handle these. This is fine as far as it goes).

4. The long-term psychotic (we are in somewhat deeper water)

   a. Those new cases, i.e., a year old, who slip through the treatment net.

      (We heard Dr. Balester's statistics yesterday that 50% of new admissions return to the community in 15 weeks. But at the end of a year's time

there are still, as it looks now, 10 to 15% who apparently aren't going to return unless we can find some better treatment methods).

b. The old cases

Here is the rub--the need to correct past mistakes. If psychosis is remediable at all by whatever formulation we use, these cases by definition must be remediable. They require attention. From this point of view the concept of front line and second line echelons as manifested by the already discarded concept of receiving and transfer hospitals is regressive and to me painful, almost physically--a kick in the guts.

5. Geriatric problems.

6. Severely afflicted or disturbed children who cannot be managed in residential treatment centers for well-adjusted geniuses--real heartbreakers.

7. Sociopaths and social misfits of various sorts who come to us whether we like it or not.

Strategically it seems to me that one must deploy forces so that the greatest strength must be available to meet the severest onslaught, the most effective striking force to face the greatest threat, the most ample resources to carry the heaviest burden.

From this point of view for now (and I think for the next several decades) the hospital program must be the heart, guts, and backbone of a mental health system. What is the most important part of the body? If I have only heart, guts and backbone I am not much. But if I lack heart, guts or backbone, or if they atrophy, I die.

Prevention is the answer of course. When we can speak with authority of the prevention of schizophrenia or of pathologic senescence then we can talk business. Until then, at least until we understand more fully what the pathology consists of, I see no option but to do things this way.

I submit that a serious imbalance exists now in the Minnesota mental health program: the talent and the public support are dispersed inequitably in relation to the magnitude of the task. While having no intention of neglecting in any way the Community Mental

Health Program, I must pledge myself to building up the hospital program to the best of my ability, to restore the balance. I imagine that you will not disagree with this intention. But would you still feel the same if the present salary discrepancy were by some chance reversed?

(Now I realize this is a low blow, but this is one aspect about which there is considerable public comment about the imbalance which now exists.)

One of the major sessions of last year's meeting at Duluth had to do with hospital-community relationships. One of the major factors behind the organization of the first Community Mental Health Workshop was my concern at that time about a separation of the hospital and community programs. I still have this concern, and will continue to have it.

Hospital-Community Relationships. Let me speak now specifically about hospital-community relationships. I will discuss three more or less related aspects of this, partly by way of information and partly to point out a continuing real problem affecting patient care.

1. Accreditation by the Joint Commission on Accreditation of Hospitals. In a statement released to the hospital superintendents on July, 1960, as in effect my inaugural act, I called upon them to achieve Accreditation by the Joint Commission in three years' time. Without going into detail on this, I simply point out that the key to JCAH Accreditation is organization of the hospital's medical staff. I would like to see more of you psychiatrists in the community program involved in hospital affairs as part of the active and consultative staffs, or at the very least on the honorary staff, on the basis of your own formal application. We already have active staff level participation medically in at least two centers and I would like to see more of this. I would hope that your appointment to the hospital staff would not simply be a paper affair but that you would participate in hospital affairs both at the clinical and at the self-analytic, policy-making committee-work level so important to the formal achievement of Accreditation and more urgently to the real maturity of the hospital as a first-class medical facility. Let me add that I think this goal is attainable.

2. Open Hospital. This was again part of my document presented to the superintendents--in this instance I gave two years as a deadline for the achievement of this. Here I will read from the document which I distributed at that time, and will quote from both Robert Hunt and myself. First a quote from Robert Hunt: I said, "The rationale of the open hospital is set forth so clearly and succinctly in the following statement by Robert Hunt that no further clarification is necessary:

"1. The enormous disability associated with mental illness is to a large extent superimposed, preventable and treatable.

"2. Disability is superimposed by rejection mechanisms stemming from cultural attitudes.

"3. Hospitalization as such is an important cause of disability.

"4. The best of treatment-minded state hospitals perform a disabling custodial function.

"5. The custodial culture within a state hospital is largely created by public pressure for security.

"6. Some of the treatment functions and most of the custodial functions should be returned to the community.

"7. This can be established by a change in public attitudes and concepts of responsibility.

"8. Public attitudes cannot be expected to change until hospitals demonstrate the value and safety of community care by becoming open hospitals."

"This is in effect a manifesto and is hereby adopted as an article of faith."

I think the implications for your responsibility here are quite obvious.

I added then in this document some comments of my own which I will read to you: "As to definition the concept of open hospital embraces more than the simple act of unlocking doors. It refers to a therapeutic rather than a custodial environment. It furthermore implies the following:

1. A rapid move of new patients in and out of the hospital.

2. Activation and rehabilitation (counter-institutionalism if you will) of long term psychotic or deteriorated patients and their return to the rightful place in

the general community.

3. Maximal development of individual and social responsibility among the hospital population.

4. Decline of hospital population as a result of movement out.

5. The minimal use of any form of physical restraint.

6. A medical rather than a juridical approach to the admission process with emphasis on medical and voluntary commitment.

7. In all respects and at all levels freedom of interchange and communication between the hospital community and the community-at-large, and establishment of the hospital as a true community resource."

I want to comment very briefly on two of the Items:

Item 6, the matter of voluntary commitments. Here the superintendents will have to cooperate, with God's help--although I am not sure how much God has to do with this. I think I can get them educated around to the point where voluntary commitments will be used a good deal more widely than they are at the present time. Item 7--the free communication between the hospital community and the community-at-large. This is the key element from your point of view. I recall your minds to Mrs. Karlins' discussion last night. Here again the hospitals will have to cooperate and break down their long-established medieval insularities and increase their social permeability. But I would hope that you, including all staff professionals and board members, county welfare people, would be more than willing to meet the hospitals half-way. Again I point to volunteer workers as a significant instrument in effecting and maintaining hospital and community relationships--as in a colloidal solution: I hope that you can find some way of hooking on to the other side.

3. Preadmission and Aftercare. This is the proof of the pudding--what happens to the patient. I have heard more than I care to: "The clinics do us no good--they send us patients who should be kept in the community or they have refused to see the patient, and they don't help us with aftercare."

Misconceptions exist and I have been very careful to point out to my hospital

friends that the Community Mental Health Center by law has many other functions than providing aftercare for mental hospital cases. I see varying levels of care which must be provided for the discharged patient: social services (mediated for example by the County Welfare Department); medical (as against psychiatric) care; close individual counseling or therapy; and complex ataractic drug management. I see a need for some division of function here, since no one agency can be expected to do them all. Actually there is a problem of course about the coordination of these services, but there is no problem in theory. I think this is the only practicable solution at the present time. The fact is that many hospitals under one guise or another are providing aftercare services, especially for their heavy medication group.

Here as in preadmission services there is no point in attempting a central dictation as to how this should be done. The key to it, it seems to me, is free communication between the Community Center and the hospital. Call on your hospital people--they are not such a bad lot, and the situation will improve if salaries and program can be brought up--invite them to visit your Centers and become acquainted with your operation. And they are only a few seconds away by telephone.

Let me remind you also of your obligation under law to provide services for the mentally retarded. Everything I have said here applies also to the mentally retarded, whether in or out of the hospital.

We have a long, long way to go in implementing adequate pre and post-hospital services. We will have to work out the patterns, probably without any precedents. Solutions arrived at in England or New Hampshire or Tennessee will not necessarily apply to us, nor will the solutions arrived at in Mower County apply to Crookston. I think the variety of services, geography, etc., etc., is so rich that there is no set or uniform pattern that we could possibly contemplate.

<u>Community Mental Health Services</u>. Now I want to make some comments about the community program as such. Here I will try to incorporate some of the things that I think Dr. Dörken was going to mention.

Another parable. Once a family bought a puppy and everyone was very pleased. It was so cute that even when it wet on the rug no one minded too much. Four years later it had grown into a very large Great Dane requiring three pounds of meat a day. (I din't know how to end this, so will say its masters were so apprehensive that they had to go back and consult their family therapist).

We will be making a request totaling two million dollars for the biennium in support of the community program. We have good documentation of this. Without going into detail, I will mention some of the factors.

1. Continuation of existing programs.

2. Establishment of new centers. At least three are in varying stages of active formation. The ultimate aim is to cover the state, although we do not expect this to be accomplished during the next biennium. A point here: in order to cover new areas, is it better to start new centers or expand old ones? A little of both is the answer, I imagine, though the evidence suggests that multiple small centers will do better than a few large ones. (cf. Balester, Vail).

3. Consolidation. Not to be confused with enlargement. It simply means consolidating staff to the point where it can cover the population involved. I think our leading example here is St. Cloud, where we have at the present time one team covering a population of some 120,000 people or possibly more.

4. Increase in salaries and operating expense: more on this below.

State money even at the $2,000,000 level starts running out at about this point. With enhanced recruitment the old days of fat reversions and margin operations are about over.

5. Enlargement of services provided. Examples: child therapy, group therapy, speech therapy, and marital counseling, by experts in these various fields. These ventures get into the experimental area to some extent. For these we will be using Federal mental health funds, now thankfully coming in at the $100,000 per year level. I have given actual examples.

Other examples of the use of Federal funds:

a. A social scientist for the center at Grand Rapids to evaluate social problems among Indians and other marginal socio-economic families in this region. I might mentic that the Federal people are very much excited about this and I think it's going to be a very interesting project.

b. Organizational funds for new boards. This is a one cent per capita matchable grant to centers in the process of formation to assist them in board meetings, recruitment, and so forth.

c. A mental health epidemiologist working out of Central Office. This would be someone with the necessary background in public health who could help us guide the further development of the program as a whole, speaking not just of the community but also the hospital program.

d. State and regional workshops.

e. Other special teaching exercises and consultation.

I mentioned earlier my role as a student of rumbles. A fair share comes in through the county welfare channels which I mentioned.

Now a few facts of life: 1. As public servants, whether state or local, we live in a goldfish bowl; 2. In contrast to the Scriptures, it is better for the elective official that one crank be placated than a hundred faithful workers receive their just praise. The lunatic fringe assumes an exaggerated importance; 3. A significant anti-professional and anti-intellectual bias exists in public life. This is dynamically the other side of the ambivalence which otherwise casts us in an omnipotent role. As professional people become more businesslike the previous images become distorted and ultimately shattered. I am not saying that this is wrong. But one side effect is that pent-up hostility can be very suitably directed by the public at its captive professional public servants. Put yourself in the position of a legislator who has just been stuck with a heavy medical bill and in legislative session hears a proposal that medical salaries in state service be boosted to a level higher than the salary which he himself is earning; 4. Attack, when it comes, is more often than not highly personal. You will I am very sorry to say, be shortly reading or hearing of some difficulty involving

a few hundred dollars worth of groceries. We may not recover from this in time for legislative session and we may never recover. Salaries and fringe benefits, if greater than those offered comparable workers, are the object of envious attack.

In the light of all this, I urge you to be one hundred percent public relations specialists. Be nice as pie to your referring agencies, make every effort to see their patients, give them the fairest possible break, answer every letter you get. I had a secretary once who used to say, concerning notification of relatives about accidents in the hospital--"a paragraph for every broken bone". I think that the principle expressed here is a valid one. We must never forget that we eat at government's table and are sheltered in government's house and that we are absolutely dependent on public good will.

Last, a bit of philosophy dealing with the old problem of diversity. This is again from my document to the superintendents. As I read this, substitute in your own mind Program Director for Superintendent,. I think the same principles apply.

"There has been and will continue to be discussion pro and con on the issue of uniformity in the operation of our hospitals. This is ultimately a constitutional problem, to be resolved by the balance of authority which exists between the hospital superintendents, who properly desire sufficient individuality so as to be able to carry out their assigned missions with professional freedom and with the opportunity for creativeness according to their own lights, and this office, which with equal propriety, in view of its responsibility to the executive and legislative government and the people, requires some measure of consistency of form and a full measure of unity of purpose. Our problem is analogous to that at the national level in the balance of sovereignty of the federal government and the various states.

A most sublime statement of national purpose is the motto over the door of the U.S. Supreme Court Building in Washington. This reads: "Equal justice under law." There is no requirement that laws in various localities be uniform. But justice must be equal everywhere. By the same token, I am interested not primarily in uniformity of method but in equality of service at a standard of excellence. This interest is dedicated to the end

that patients under treatment in all of our institutions or mental health centers will have an equal opportunity to get well and return to their rightful places in society: equal among ourselves and equal to the opportunity for the mentally ill and mentally retarded which exists anywhere."

Thank you.